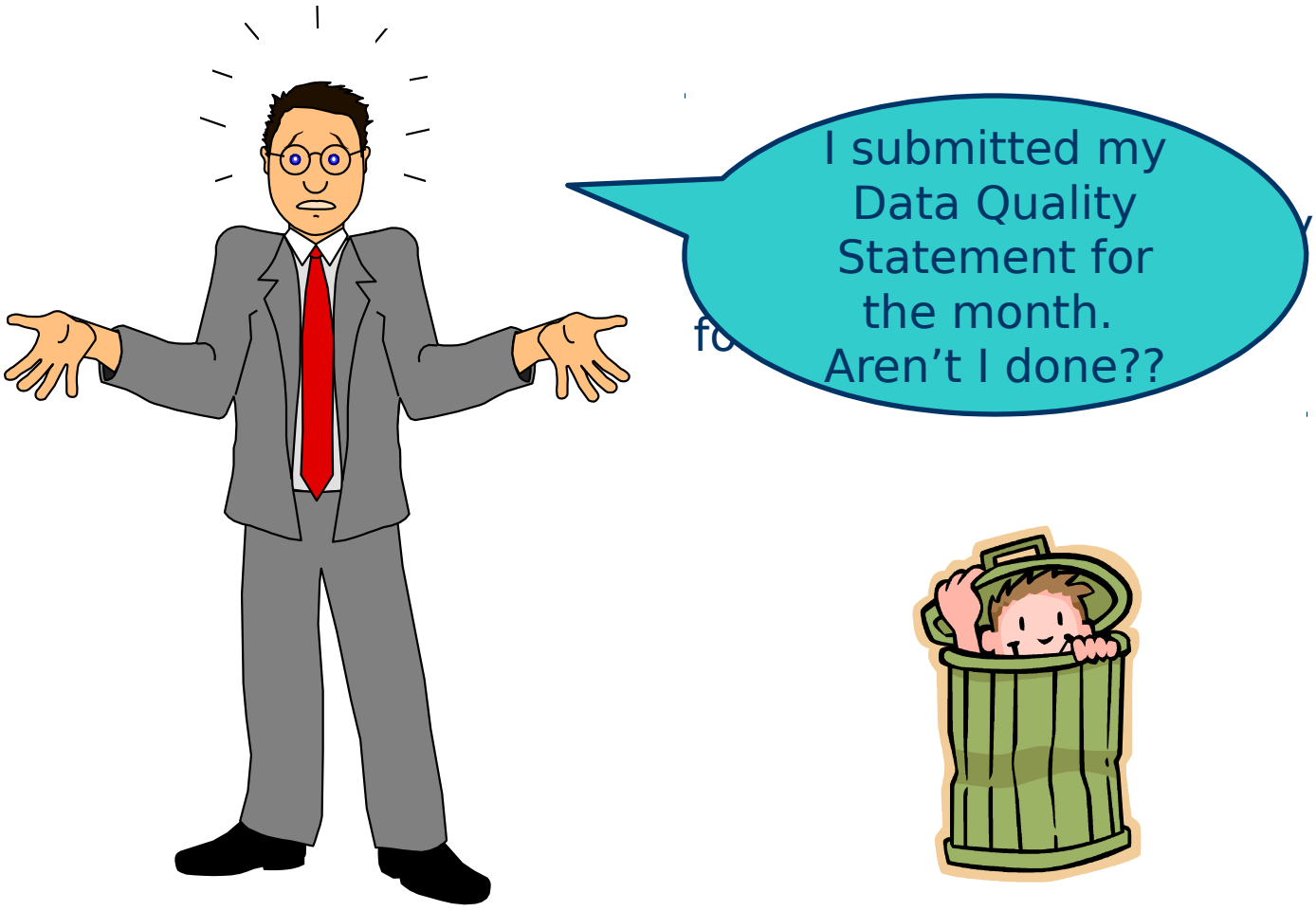
TRICARE Management Activity
Uniform Business Office

Coding Overview and the DQ Manager

September 2011

Why Worry About Data Quality?



Why Worry About Data Quality?

Internal and External Scrutiny
Audit – TMA and Coast Guard

It Takes a Team

- You are the gatekeeper monitoring the data flow
- It takes a team to be successful
  - DQ Manager, Resource Management Office (RMO)/Patient Administration, MEPRS/EAS Coordinator, Credentials Manager, Budget Analyst/Uniform Business Office (UBO), Coding/Billing Supervisor, Clinical Systems Administrator(s)
- Are processes in place to assure data integrity?
- Are provider files set up correctly?

First Priority

- Make it a Partnership - Providers and Coders
  - AHLTA/Essentris training – Providers, trainer AND Coder/Auditor
  - Use of templates to streamline documentation
    - Must be updated at the same time as code tables
  - Feedback and training to provider – YOU NEED TO CLOSE THE LOOP!
  - We are in this together - communicate
  - Current coding resources need to be available for clinic, provider and coder/auditor use

Second Priority

- Ensure there is a process in place to identify AND to audit all billables!
  - Run report to identify encounters
    - CCE worklist **OR**
    - Run Preview List in CHCS
  - Perform audit of coding
    - Correct errors
    - Query provider if documentation is unclear
- Don’t let a bill go out the door without an audit!

Coding Compliance

- The key to coding compliance is
  - Correct documentation
  - Correct codes
  - Correct guidelines
  - Standardized audit methodology

Purposes of Coding

- **Validates medical <u>necessity of services</u> based on diagnosis**
- Identifies why patients are being seen
- Identifies and quantifies the services you have provided
- Permits retrieval of information for users
  - Research and Benchmarking
  - Administrative and funding decisions
  - HEDIS reporting
- Key to Population Health - identify trends

Types of Coding

- ICD-9-CM
  - Diagnoses used for all types of encounters/admissions
  - Procedures used only for inpatients
  - MS-DRGs are based upon these codes
  - Updated annually 1 October
- CPT
  - E&M and procedure codes
  - Updated annually 1 January
- HCPCS
  - Supplies, pharmaceuticals/injectables
  - Updated annually 1 January

ICD-9 & ICD-10 Code Freeze

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2014, regular updates to ICD-10 will begin.

ICD-10

- Tenth addition of ICD was issued in 1993
  - Currently used in Europe and Canada
- 5010 electronic transaction standards requirement by 1 January 2012
- US ICD-10 Compliance date is 1 October 2013
  - ICD-10-CM has expanded upon ICD-9-CM
  - ICD-10-PCS requires building a 7 character code
  - Requires coding and documentation training
  - **NO GRACE PERIOD FOR IMPLEMENTATION**

Coding Basics

- Codes are assigned based on documentation
- Diagnosis codes are assigned differently based on the setting (inpatient or outpatient)
- Military Health System has special coding requirements and are needed to accurately reflect services that are unique to the military.

http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm

Medical Necessity

- "Outpatient Admissions" don't exist
  - Admit only if there is medical necessity
    - Ambulatory Procedure Visit patient remains after the Ambulatory Procedure Unit closes for the evening is not an admission
    - Patient remaining past midnight is not an automatic admission
    - Patient in observation in the ED more than 24 hours is not an automatic admission
  - EXCEPTION: Placing a patient in a bed on the ward for Observation creates an admission (per "Policy for Billing of Observation Services in Fixed Military Treatment Facilities," dated August 2, 2011)
  - Refer to Coding Guidelines and UBO User's Guide for specific coding/billing guidance

DoD Unique Diagnosis Codes

- DoD Extender Codes
- Root code V70.5 Health examination of defined subpopulations
- V70.5_0 Armed Forces medical exam
- V70.5_1 Aviation Exam
- V70.5_2 Periodic Health Assessments (PHA) or Prevention Assessment
- V70.5_3 Occupational exam

Utilize existing codes for unique reporting

- 99199 is used to identify the Institutional component of an APV

- Case Management:
  - G9002 Monthly CM Summary Reporting – Acuity level 1
  - G9005 Monthly CM Summary Reporting – Acuity level 2
  - G9009 Monthly CM Summary Reporting – Acuity level 3
  - G9010 Monthly CM Summary Reporting – Acuity level 4
  - G9011 Monthly CM Summary Reporting – Acuity level 5

Inpatient Record

- An admission generates an institutional record based upon the MS-DRG = SIDR
  - MS-DRG based upon correct assignment of ICD-9 diagnoses and procedures
    - MS-DRG accuracy is reported for 5.a.
    - Data elements within MS-DRG is on the Review List (C.5.c-d)
      - All diagnoses, any Procedures done, Sex and Age of patient, Discharge/Disposition
  - Medical Severity DRGs (MS-DRG)
    - Diagnoses requires supporting Present on Admission (POA) Indicators
    - CCE updated to add POA
    - **CHCS 11-segment SIDR implemented Nov 2010**

Inpatient Record - Rounds

- An inpatient professional services encounter or rounds (formerly called IBWA) = **“A” CAPER**
  - Services performed by the Attending Service
  - E&M and procedures performed
  - Same records as the MS-DRG audit
  - Inpatient Hospital Visits and follow-up captured in the **“B” CAPER**

Inpatient Record - Rounds

- Auditing Sampling Methodology (for questions C.5.f,g,h)
  - **One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample.**
    - For hospitalizations which begin and terminate the same calendar day, that calendar day will be audited.
    - For all other hospitalizations, the registration number will determine if services for the first or second calendar day will be audited.
    - **Odd registration numbers** will be audited for the **first day** and **even registration numbers**

Outpatient Record

- Professional services are coded and generate a “B” CAPER
- The following services are considered outpatient:
  - Clinic
  - Emergency Department
  - Observation status in the ED with doctors written order
  - APV (Same Day Surgery)
  - Consults
  - Rounds are captured in the **“A” CAPER**

Timeliness

- Question 2 - Was your facility compliant with the following metrics?
  - What percentage of Outpatient Encounters, other than APVs, have been coded within 3 business days of the encounter? **(B.6.(a))**
  - What percentage of APVs have been coded within 15 days of the Encounter? **(B.6.(b)**
  - What percentage of Inpatient records have been coded within 30 days after discharge? **(B.6.(c))**

Completeness

Encounters/admissions must be complete in order to code:

- Patient identification is correct and present
- Dated
- Signed (ink or electronic signature)
- Legibility (if paper)
- Documentation is complete
  - Patient medical history
  - Reason for encounter
  - Assessment and Plan
  - Surgical report (if applicable)

Completeness

- Review List C.5.a,b
  - Percentage of inpatient medical records located?
  - Percentage of documentation that was complete.
- Questions 6a, 7a
  - Is adequate documentation of the encounter selected to be audited available? Documentation includes documentation in the medical record, loose (hard copy) documentation or an electronic record of the encounter in AHLTA. **(C.6.a, C.7.a)**

Accuracy

- Questions 5a-d, 6b-d and 7b-c
- Was the MS-DRG correct (inpatient)?
- Was the Primary Diagnosis (outpatient) present and in the first position?
- Was the E&M code correct and present (non-APVs)?
- Was the Primary Procedure (outpatient) present and in the first position?
- NOTE Refer to Appendix F “Coding Audits” of the MHS Coding Guidelines.

TMA/UBU calculation methodology:

$$\frac{\text{Number of correct codes}}{\text{Total number of codes}}$$

- Provides standardized business rules across MHS
- More accurate representation of metric

Consistency

- Was there a sudden change in metrics - what happened?
  - Software change
  - Table update
  - Change in staff
  - System is down
- Did you file a trouble ticket?
- Did you put a comment on your Data Quality Statement to explain identified problem and estimated correction date?

Trending

2b. % APVs coded in 15 days

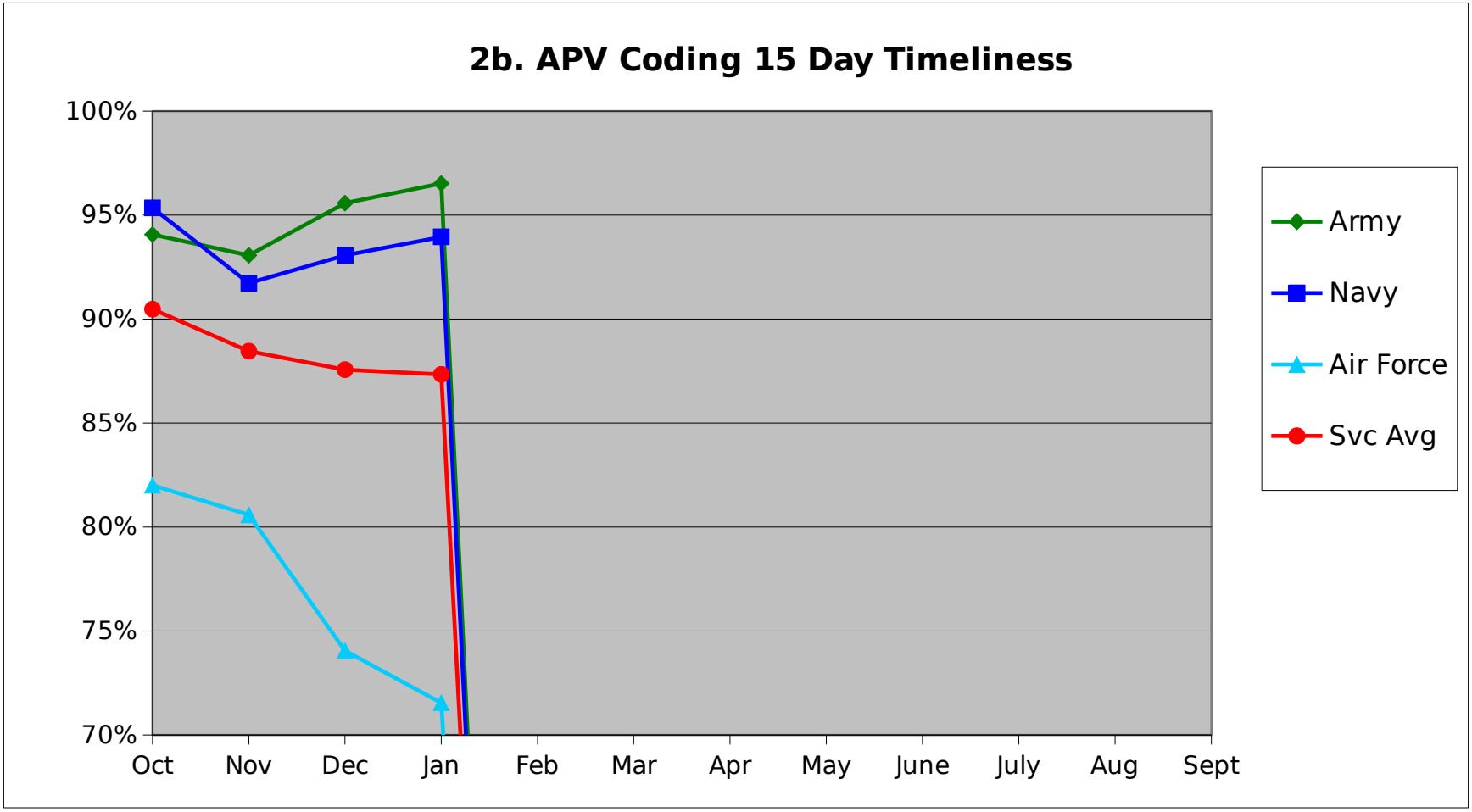
	Regions	DQ Reporting Facility Name	
6		BAVARIA MEDDAC	
7		LANDSTUHL REGIONAL MEDCEN	100%
8		HEIDELBERG MEDDAC	75%
9	ERMC Average		
10		DEVITT ACH-FT. BELVOIR	100%
11		GUTHRIE AHC-FT. DRUM	22%
12		IRELAND ACH-FT. KNOX	100%
13		KELLER ACH-WEST POINT	90%
14		KENNER AHC-FT. LEE	
15		KIMBROUGH AMB CAR CEN-FT MEADE	99%
16		MCDONALD AHC-FT. EUSTIS	100%
17		WALTER REED AMC-WASHINGTON DC	95%
18		WOMACK AMC-FT. BRAGG	100%
19	NRMC Average		
20		121st CSH-SEOUL	99%
21		BG CRAWFORD SAMS AHC-CAMP ZAMA	
22		TRIPLER AMC-FT SHAFTER	97%
23	PRMC Average		
24		BAYNE-JONES ACH-FT. POLK	87%
25		BLANCHFIELD ACH-FT. CAMPBELL	98%
26		BROOKE AMC-FT. SAM HOUSTON	85%
27		DARNALL AMC-FT. HOOD	98%
28		EISENHOWER AMC-FT. GORDON	46%
29		FOX AHC-REDSTONE ARSENAL	
30		LYSTER AHC-FT. RUCKER	
31		MARTIN ACH-FT. BENNING	100%
32		MONCRIEF ACH-FT. JACKSON	96%
33		REYNOLDS ACH-FT. SILL	99%
34		VINN ACH-FT. STEWART	92%
35	SRMC Average		
36		BASSETT ACH-FT. WAINWRIGHT	99%
37		EVANS ACH-FT. CARSON	99%
38		IRWIN ACH-FT. RILEY	101%
39		L. WOOD ACH-FT. LEONARD WOOD	100%
40		MADIGAN AMC-FT. LEWIS	99%
41		MUNSON AHC-FT. LEAVENWORTH	100%
42		R W BLISS AHC-FT. HUACHUCA	

95% - 100%
80% - 94%
79% and Below

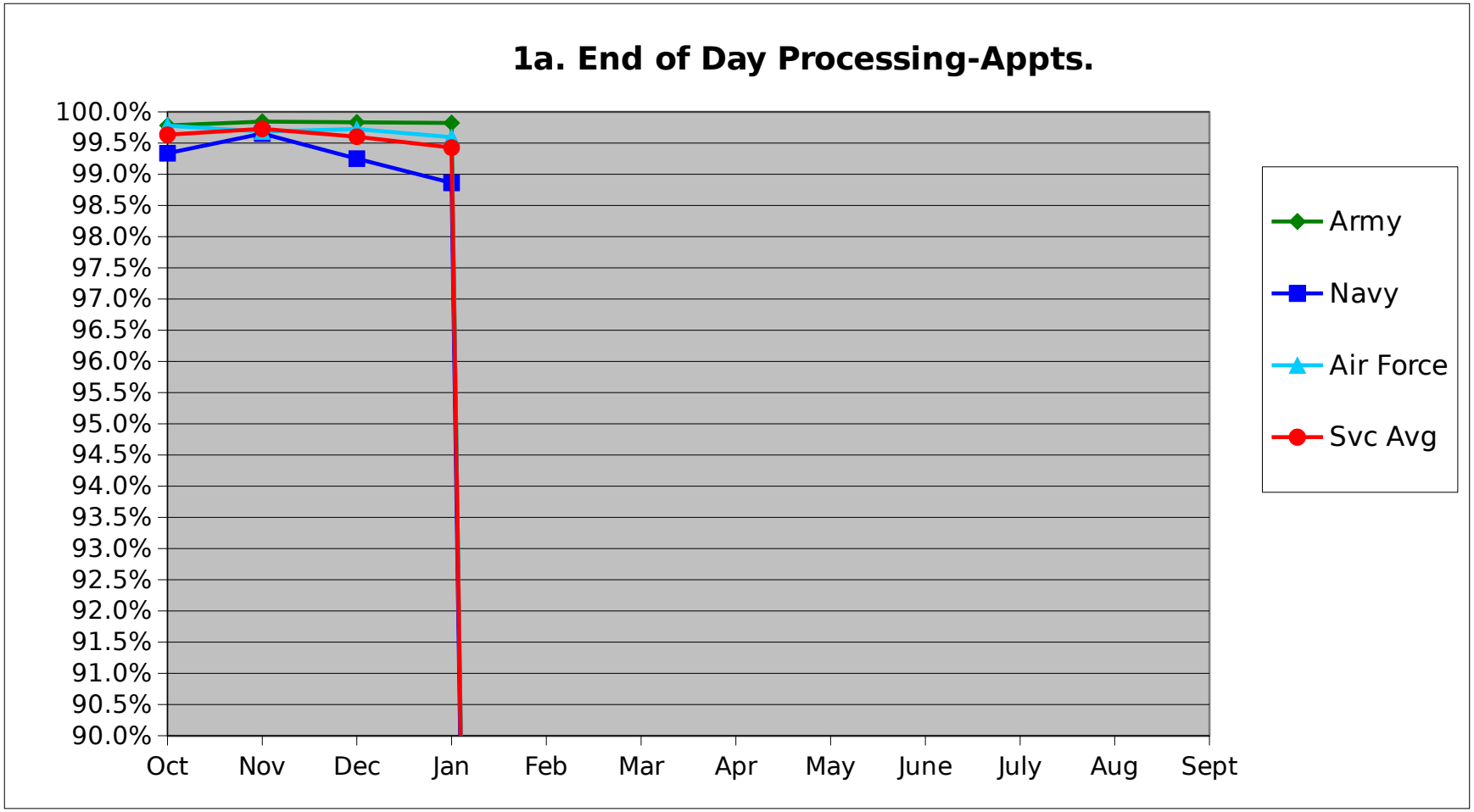
Comments from DQ Statement

- New tracking method for APV records flow to decrease missing records affected staff's progress/Coders will monitor
- Continue to educate, work with providers and clinic staff on completing APV records within a timely manner
- Operative report dictation delays and incorrect APV appointments. Increased monitoring of compliance.
- Shortage of coders in APV section. Additional coders being trained in APV section.

Trending – FY11



Trending – FY11



Reports Relating to Coding

- ADM Write-Back Error Report
  - Look at error types
  - Correct the ones you can
  - Monitor the ones corrected at corporate
- No ADM
  - Kept appointments that have not been coded
  - Missing SADRs/CAPERs (Comprehensive Ambulatory and Professional Services Record)
- SIDR Transmission
- Make sure you get credit for the work you've done!

Write-back Errors

- ERR: 109 Patient DOB Invalid.
- ERR: 209 Appt_status not SADR/CAPER eligible.
- ERR: 215 Provider IEN null or missing.
- ERR: 218 ICD9 Level missing or invalid.
- ERR: 222 Disposition missing based on status.
- ERR: 226 Secondary provider not valid or missing.
- ERR: 229 Second Secondary provider not valid or missing.
- ERR: 232 CPT4 code not valid.
- ERR: 234 ICD9 code is not allowed for cancelled appts or Disp = LWOBS.
- ERR: 236 Disposition not allowed for cancelled appts or tel-cons for priv HCP.
- ERR: 240 Found E&M code where not allowed.
- ERR: 243 Ambulatory flag set where not allowed.
- ERR: 251 Disposition Type does not match Patient Status.
- ERR: 254 Injury Related data missing, based on ICD9 codes.
- ERR: 257 Supervising Provider is required.
- ERR: 258 Appointment Provider Specialty Code missing.
- ERR: 259 Appt Provider is not assigned HIPAA Provider Taxonomy Code

Write-back Warnings

- WARN: 453 No provider associated with a CPT code.
- WARN: 454 Injury Related data missing, based on ICD9 codes.
- WARN: 457 Supervising Provider is required.
- WARN: 458 Place of Employment missing based on Injury Cause Code of EM.
- WARN: 460 Place of Accident missing based on Injury Related flag
- WARN: 460 Place of Accident missing based on Injury Related flag.
- WARN: 462 Geographic Location not allowed when no AA cause code is present.
- WARN: 465 Provider NPI missing.
- WARN: 467 Appt Prov Taxonomy is not mapped to one of provider's specialties
- WARN: 468 Taxonomy for Prov #2 is not mapped to one of provider's specialties
- WARN: 469 Taxonomy for Prov #3 is not mapped to one of provider's specialties
- WARN: 470 Provider #2 is not assigned HIPAA Provider Taxonomy Code.
- WARN: 471 Provider #3 is not assigned HIPAA Provider Taxonomy

Medical Record Documentation

Complete Documentation

Correct Coding

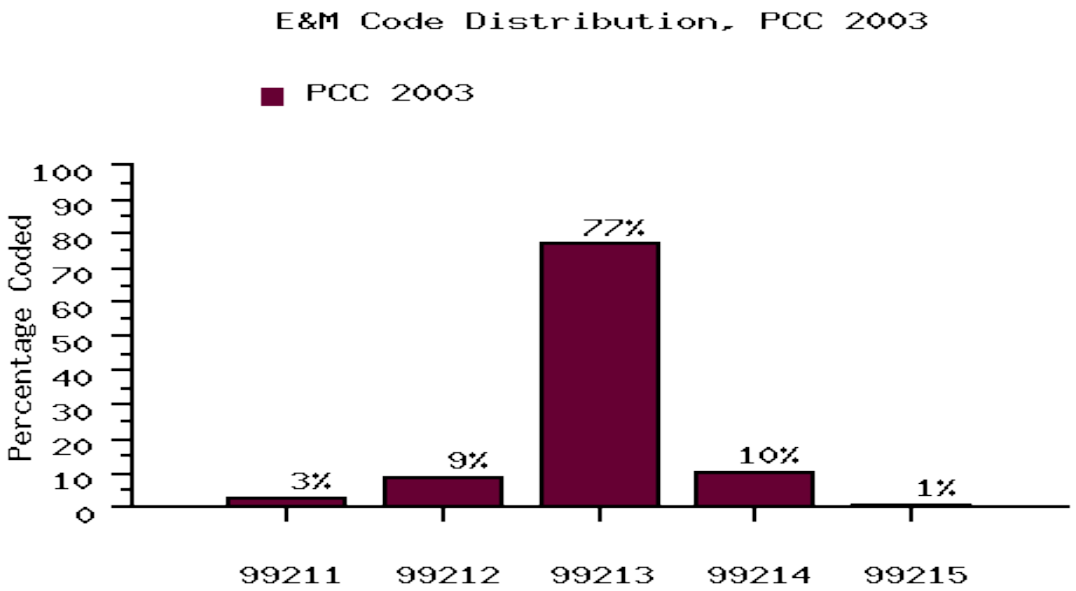
Appropriate Reimbursement and Workload

<u>The critical factor in determining the level of care</u>:

Not what you did….but what you documented!

Relative Value Units

- The currency of the MHS
- Measured at all levels, including individual provider level
- Used for benchmarking



Relative Value Units (RVUs)

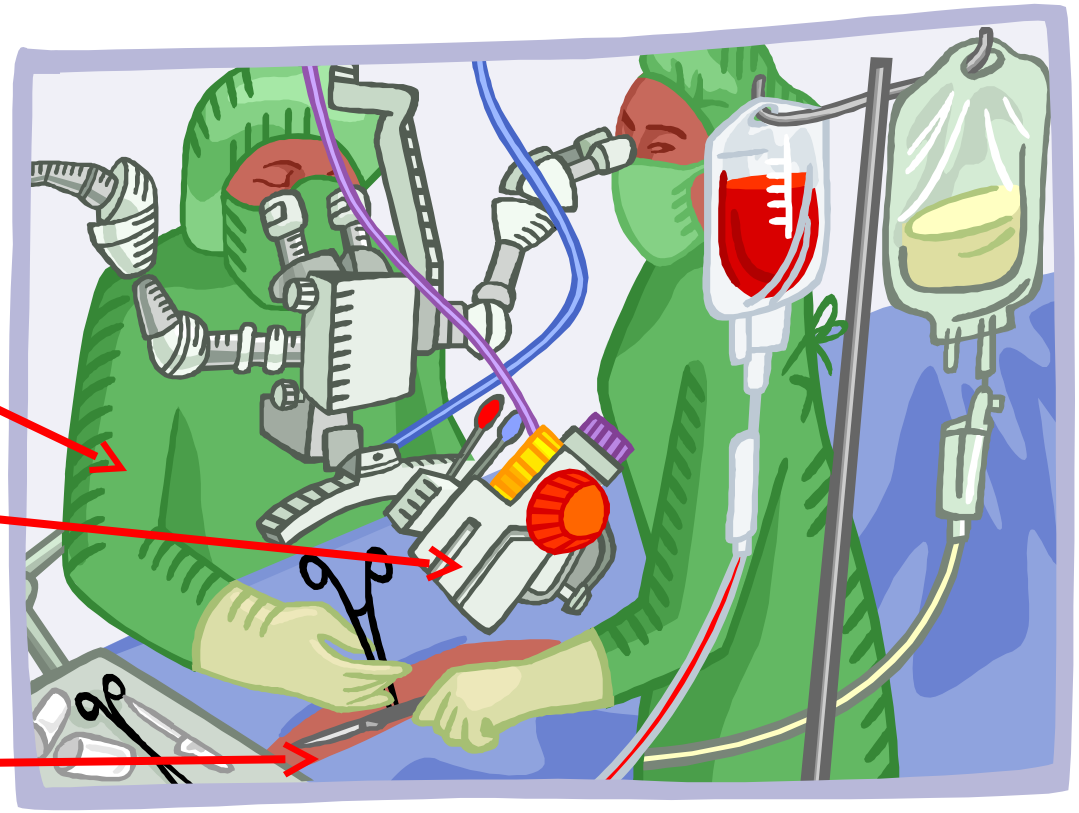
- Are a way to compare resources used to produce a product
- Examples of products are:
  - Office visits
  - Excision of a lesion
  - Delivering a baby

What do the components look like?

“Work”

“Practice Expense”

“Malpractice”



ED Example

- Patient seen in Emergency Department (ED) after getting in a fight with a Thanksgiving Turkey and a knife
- ED doctor documents ER visit to include 4 stitches in palm of left hand and tetanus shot
- Coded with 99282-25, 12002-LT, 90703, 90471

Code	Work RVU	Practice Expense RVU
99282 ED visit	0.88	0.19
12002 stitches	1.53	0.74
90703 tetanus	0	0.62
90471 injection	0.17	0.41
TOTAL	2.58	1.96

Workload Capture

- Impact of Provider Specialty Code (PSC)
  - Proper HIPAA Taxonomy Code should be linked to correct PSC
  - PSC 910 and above are Clinical Services
  - Do not use
    - PSC 000 (DMO) as a default
    - Codes 500 – 518 and 910 – 999
- Bottom line – missing or incorrect PSC = 0 workload!

Value of Care

- PEDIATRICS – BDA
- Provider Specialty Code = 949
  - Pediatrics
- Diagnosis Codes
  - 204 Lymphoid Leukemia
  - 112.89 Candidial Endocarditis
- Procedure Code
  - 90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
  - 90781 – Each additional hour
- E&M Code
  - 99214 – Level 4 Established Patient
- OHI – Yes
- CMAC Value = UNKNOWN
- Will you bill for this patient? NO
  - Reimbursement $0
- PPS Workload = *ZERO!!!!!!*

- PEDIATRICS – BDA
- Provider Specialty Code = 040
  - Pediatrician
- Diagnosis Codes
  - 204 Lymphoid Leukemia
  - 112.89 Candidial Endocarditis
- Procedure Code
  - 90780 Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
  - 90781 – Each additional hour
- E&M Code
  - 99214 – Level 4 Established Patient
- OHI – Yes
- CMAC Value = $130.73 Class 1 Provider
- Will you bill for this patient? Yes
  - Reimbursement - $130.73
- PPS RVU = 1.44 Reimbursement = $106.56

Provider File Issues

- Provider Naming Conventions
- Provider ID
- NPI – null or duplicate = **NO $$$**
- Provider Class
- PSC and HIPAA Taxonomy
- External Providers
  - SSN not mandatory
  - Need either DEA# or License #

Other Provider File Issues

- External Providers – adding new providers for Ancillary Services
- Internal Providers - Incoming
  - Credentials pulls data from CCQAS and verifies credentials
  - Build profile in CHCS
- Providers – Outgoing
  - Inactivate Provider from Patient and Appointment System (PAS) profile(s) and the Managed Care Program (MCP) Provider Group(s) as required
  - Order Entry Inactivation
    - Date in which the provider can no longer accept *New* orders
    - This does not prevent existing orders to process
  - Termination Date
    - Date in which the provider ceased to be employed by the MTF
    - Terminate – after 1 year

Incorrect fields in red:
PROVIDER: SMITH, JOHN R

Name: SMITH, JOHN R
Provider Flag: PROVIDER
Provider ID: Provider1234
NPI Type/ID:
Provider Class: Doc
Person Identifier: 123-45-6789
Person ID Type Code:
Select PROVIDER SPECIALTY:
517 (DENTAL CONSULTANT)
Primary Provider Taxonomy:
CMAC Provider Class: -
Select PROVIDER TAXONOMY:
HCP SIDR-ID:
Location: CHAMPUS SUPPORT
Class: OUTSIDE PROVIDER
Initials: JRS
SSN: 123-45-6789
DEA#: 99999999
License #:

Corrected fields in red:
PROVIDER: SMITH,JOHN R

Name: SMITH,JOHN R
Provider Flag: PROVIDER
Provider ID: SMITHJR
NPI Type/ID: 01/0125899
Provider Class: OUTSIDE PROVIDER
Person Identifier:
Person ID Type Code:
Select PROVIDER SPECIALTY:
001 (FAMILY PRACTICE PHYSICIAN)
Primary Provider Taxonomy:
207Q00000X
CMAC Provider Class: -
Select PROVIDER TAXONOMY:
HCP SIDR-ID:
Location: CHAMPUS SUPPORT
Class: OUTSIDE PROVIDER
Initials: JRS
SSN: 123-45-6789 (Not Mandatory)
DEA#: BM1212127
License #:

Take Away

- Data Quality is not just the DQ statement.
- Use your DQ metrics appropriately
- Bottom line - your coding is as good as the documentation it is based upon
- Data needs to be accurate, timely and complete.
- Cleaning up the front end will show a return on the back end.

Useful Web Sites

- **Data Quality - http://www.tricare.mil/ocfo/mcfs/dqmcp/metrics_reports.cfm**
- **UBU - http://www.tricare.mil//ocfo/bea/ubu/index.cfm**
- **ICD-10 – www.cms.gov/ICD10/**
- **UBO - http://www.tricare.mil/ocfo/mcfs/ubo/about.cfm**
- **MEPRS – http://meprs.info**
- **DMHRSi - https://dmhrsi.satx.disa.mil**
- **MEWACS - http://www.meprs.info/mol3/mol3.cfm**
- **HIPAA - http://tricare.osd.mil/ocfo/mcfs/ubo/hipaa.c**

Questions?

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BACK UP SLIDES

Background Information

- ICD-9-CM: Clinical Modification developed in the US and implemented in 1979
  - Volumes 1&2 Diagnosis Codes (used by all providers)
  - Volume 3 Procedure Codes (used by hospitals for inpatient reporting)
- ICD-10: Diagnosis classification system developed by the World Health Organization to replace ICD-9
- ICD-10-CM: US Clinical Modification for ICD-10 diagnosis classification system
- ICD-10-PCS: US procedure classification system to replace ICD-9-CM Volume 3

ICD-10 Final Rule

- Inpatient coders on ICD-10-CM/PCS recommends 50 hours of training
- Outpatient coders on ICD-10-CM recommends 10 hours of training
- Physicians on ICD-10-CM recommends 8 hours of training
- Auxiliary staff on ICD-10-CM recommends 8 hours of training

ICD-9-CM vs. ICD-10-CM Diagnosis

ICD-9-CM	ICD-10-CM
Three to five characters	Three to seven characters
First digit is numeric but can be alpha (E or V)	First character always alpha
2-5 are numeric	All letters used except U
Always at least three digits	Character 2 always numeric: 3-7 can be alpha or numeric
Decimal placed after the first three characters	Always at least three digits
Alpha characters are not case-sensitive	Decimal placed after the first three characters
	Alpha characters are not case-sensitive

Diagnosis GEMs

ICD-10-CM	ICD-9-CM
E11341 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema	**25050 Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled** **362 Severe nonproliferative diabetic retinopathy** **36207 Diabetic macular edema**

ICD-10-CM	ICD-9-CM
S72031A Displaced midcervical fracture of right femur, initial encounter for closed fracture	**82002 Fracture of midcervical section of femur, closed**

ICD-9-CM vs. ICD-10-PCS

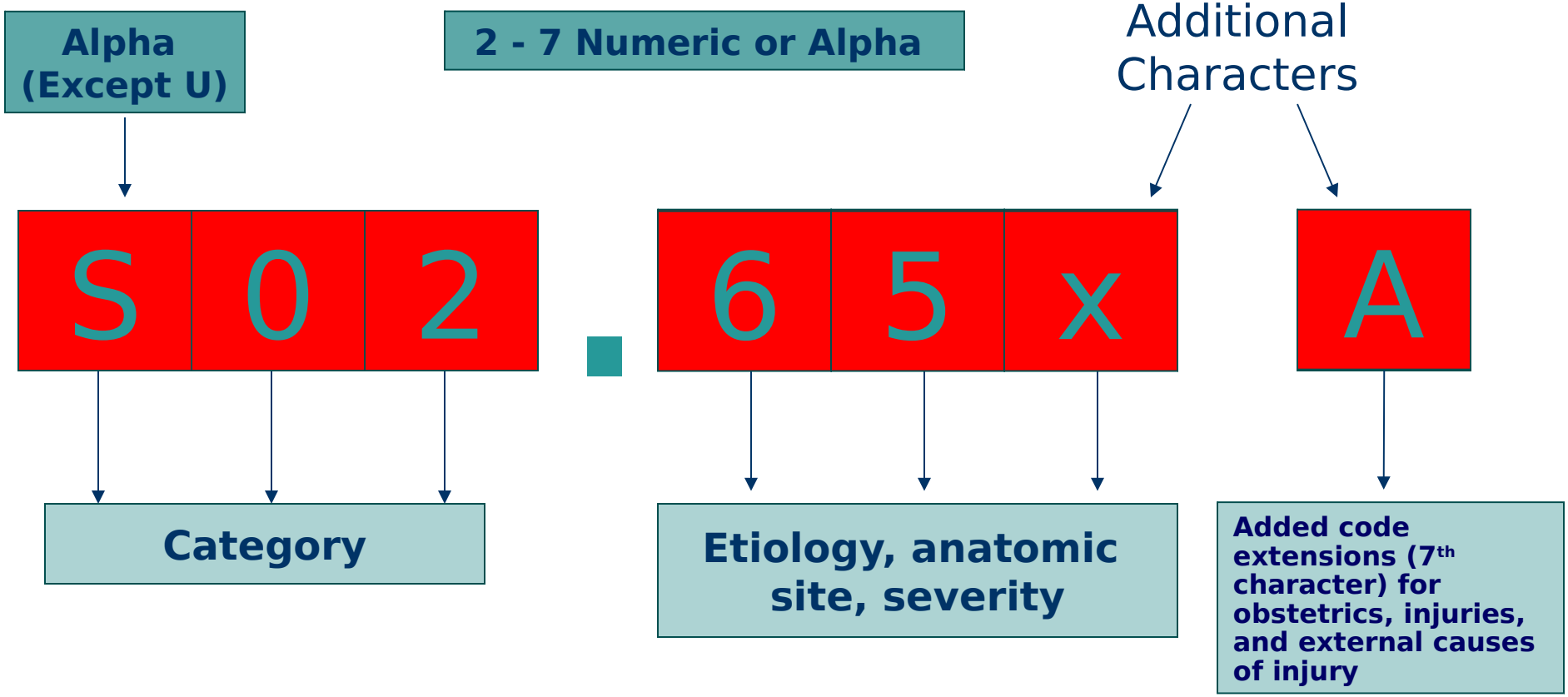
ICD-9-CM (vol. 3):

- Minimum of 3 digits/maximum of 4 digits; decimal point after the second digit
- Numeric

ICD-10-PCS:

- Minimum/maximum 7 digits; no decimal point
- Alphanumeric with all codes starting with three alphanumeric characters

Coding and 7th Character Extensions



3 – 7 Characters

Example of Procedure Coded in ICD-10-PCS

- *Laparoscopic appendectomy: 0DTJ4ZZ*
  - Medical and Surgical section (0)
  - body system Gastrointestinal (D)
  - root operation Resection (T)
  - body part Appendix (J)
  - Percutaneous Endoscopic approach (4)
  - No Device (Z)
  - No Qualifier(Z).

Example of Procedure Coded in ICD-10-PCS

- *Tracheostomy using tracheostomy tube: 0B110F4*
  - Medical and Surgical section (0)
  - body system Respiratory (B)
  - root operation Bypass (1)
  - body part Trachea (1)
  - Open approach (0)
  - with Tracheostomy Device (F)
  - and qualifier Cutaneous (4)

Procedure GEMs

ICD-10-PCS	ICD-9-CM
02713DZ Dilation of coronary artery, two sites using intraluminal device, percutaneous approach	00.66 PTCA or coronary atherectomy
	00.41 Procedure on two vessels
	00.46 Insertion of two vascular stents
	36.06 Insertion of non-drug-eluting coronary artery stents